



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

May 12, 2010

Rene Stephens
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Bitterroot Home, provider #13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Bitterroot Home, which was conducted on May 7, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Rene Stephens
May 12, 2010
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 24, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by May 24, 2010. If a request for informal dispute resolution is received after May 24, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2010
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiency was cited during the annual recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Barbara Dern, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee QMRP - Qualified Mental Retardation Professional	W 000		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs designed to manage maladaptive behavior were implemented only with the approval of the human rights committee for 1 of 1 individual (Individual #1) whose behavior modifying drugs were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's IPP, dated 7/11/09, documented a 20 year old male diagnosed with profound mental retardation, autism, and cerebral palsy.	W 262	W262 The individual in question will have Written Informed Consents, signed by guardian(s) and reviewed by HRC, explaining the risks and potential benefits of the associated program or medication. A file review will be conducted on the records of the individuals living in that home to determine if there are programs or medications that warrant having guardian and HRC approval before implementation. A systematic change has been implemented to ensure restrictive measures which require Informed consent are reviewed as part of all Individual Program Plan reviews and implementation by the QMRP(s). Semiannual reviews of records will be completed by QMRP(s) and QAM with the Facility Manager and Nursing staff to ensure that no potentially restrictive program or medication has been given appropriate scrutiny to ensure that review and approval has occurred. QMRP(s), Administrator, and QAM will monitor reviews of Q-blinders via mock survey process conducted quarterly. Date of correction: 6-30-2010	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2010
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 262	<p>Continued From page 1</p> <p>Individual #1's record contained a physician's order, dated 3/10, which documented Individual #1 received Valium 5 mg for eye appointments and Valium 2 mg for dental appointments.</p> <p>Further, Individual #1's record contained Nursing Notes, dated 3/10. The Notes included the following entries:</p> <ul style="list-style-type: none"> - "03/01/10 I notified [Guardian Name] by email [sic] that [Individual #1] would be receiving Valium 2x this month." - "03/11/10 [Individual #1] went in to see [Doctor Name] today for his annual eye exam. He did get Valium prior to the appt [sic]." - "03/18/10 [Individual #1] had his routine dental visit today while taking Valium prior to the appt [sic]." <p>However, Individual #1's record did not contain documentation that the facility's HRC reviewed and approved the use of Valium.</p> <p>When asked, the QMRP stated on 5/6/10 at 11:00 a.m., HRC consent had not been obtained and it was an oversight.</p> <p>The facility failed to ensure HRC approval was obtained for the use of Valium for Individual #1.</p>	W 262			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2010
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 BITTERROOT DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 See response for W262	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: During an environmental review on 5/5/10 from 1:15 - 1:50 p.m., the following concerns were noted: Kitchen: - The 2 lower walls leading into the kitchen contained black marks and a 1 foot area was missing paint. - The oven contained baked-on grease. Laundry Room: - The laundry room sink contained a hose attached to the faucet without a backflow device	MM380	MM380 Walls will be repaired and painted in the kitchen area. Grease will be removed from the oven - where baked on. Backflow device will be installed on the mop sink in the washroom. Stains will be removed from the carpet in the living room area. Responsible: Facility Manager, Quality Assurance Manager, Administrator Garage will be de-cluttered. Date of correction: 7-10-2010	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5559

UH5111

TITLE

(X6) DATE

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2010
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE	
MM380	Continued From page 1 in place. Living Room: - The living room carpet contained two 1 and 1/2 foot stained areas. Garage: - The floor was cluttered with a large television, 2 mattresses and a box springs, a pet carrier, and multiple boxes, creating a trip hazard.	MM380			